

The Honorable James L. Robart

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UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
AT SEATTLE

STATE OF WASHINGTON,

Plaintiff,

v.

UNITED STATES DEPARTMENT OF  
HEALTH AND HUMAN SERVICES; ALEX  
M. AZAR, in his official capacity as the  
Secretary of the United States Department of  
Health and Human Services,

Defendants.

No. 2:20-cv-01105-JLR

**AMICUS CURIAE BRIEF BY LOCAL  
GOVERNMENT AMICI IN SUPPORT OF  
PLAINTIFF'S MOTION FOR  
PRELIMINARY INJUNCTION**

**Noted for: August 7, 2020**

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## INTEREST OF *AMICI CURIAE*<sup>1</sup>

*Amici* are 31 counties, cities, and towns located throughout the United States, including throughout the State of Washington. *Amici* range from sprawling seaport cities such as Seattle, to rugged, rural mountain cities such as Driggs, Idaho. Notwithstanding our differences, *amici* are united in our opposition to the U.S. Department of Health and Human Services’ (HHS) Affordable Care Act (ACA) Section 1557 Final Rule.<sup>2</sup> The Final Rule withdraws nondiscrimination protections from many of our most at-risk residents in intimate and important healthcare contexts, gutting HHS’s prior 2016 Rule.<sup>3</sup> It eliminates Section 1557’s nondiscrimination protections based on sexual orientation and gender identity, excludes health insurance and non-ACA health programs from nondiscrimination obligations, and exempts religious entities from providing nondiscriminatory care, among other things.<sup>4</sup> In so doing, the Final Rule directly harms our residents, communities, and local governments, and erodes our ability to foster inclusive communities in which everyone has the right to respect and the opportunity to lead a healthy, independent life. By utterly ignoring these harms, HHS violates the basic requirements of administrative rulemaking. *See Dep’t of Homeland Sec. v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1915 (2020). The Final Rule should be preliminarily enjoined.

## ARGUMENT

### I. The ACA Enables Local Governments to Provide Better Healthcare

As local governments, *amici* are responsible, often by legal mandates and always by practical realities, for protecting the health and safety of our communities. We assist children and the elderly,

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<sup>1</sup> No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici* or their counsel made a monetary contribution to this brief’s preparation or submission. Counsel for all parties consented to the filing of this brief.

<sup>2</sup> Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts. 438, 440, & 460 and 45 C.F.R. pts. 86, 92, 147, 155, & 156) (“Final Rule”).

<sup>3</sup> Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (formerly codified at 45 C.F.R. pt. 92) (2016 Rule) (“2016 Rule”).

<sup>4</sup> The Final Rule imposes numerous other extremely harmful provisions, but *amici* address only these three provisions because they form the exclusive basis for the State of Washington’s preliminary injunction motion.

1 operate law enforcement agencies and jail facilities, provide emergency medical transportation and  
 2 safety-net healthcare services, and, as we have witnessed recently all across the nation during the  
 3 COVID-19 pandemic, perform critical public health work. *Amici* administer the “smaller  
 4 governments closer to the governed” “that touch on citizens’ daily lives.” *Nat’l Fed’n of Indep. Bus.*  
 5 *v. Sebelius*, 567 U.S. 519, 536 (2012) (*NFIB*). *Amici* are often the only entities with the ability to  
 6 perform these vital public functions that are necessary for our residents to be healthy, productive  
 7 members of society.

8 *Amici* are also obligated to provide many healthcare services to our residents regardless of  
 9 their ability to pay.<sup>5</sup> We do not, and cannot, condition emergency transportation in our ambulances,  
 10 examination and treatment in our public health clinics and emergency departments, emergent care in  
 11 our safety-net hospitals, or use of our suicide hotlines or mobile crisis services on one’s ability to  
 12 pay the bill. *See NFIB*, 567 U.S. at 593 (opinion of Ginsburg, J.). Thus, when our residents are less  
 13 healthy or more reliant on safety-net services, *amici* incur greater direct costs.

14 *Amici* bear massive, but avoidable, direct costs from the less effective, less timely, and more  
 15 expensive care people seek when they delay or forgo healthcare. For example, in the County of  
 16 Santa Clara, it costs thousands more to treat an uninsured person who contracts HIV/AIDS than it  
 17 does to provide that resident with preventative one-pill-a-day pre-exposure prophylaxis (PrEP)  
 18 medication. Without primary and preventative care, prescription drugs, and early diagnosis and  
 19 treatment, our residents are sicker and more costly to treat, and also more likely to access healthcare  
 20 through highly costly means, such as by ambulance calls or emergency department visits.<sup>6</sup> In the

21 \_\_\_\_\_  
 22 <sup>5</sup> *See, e.g.*, Nat’l Ass’n of Cty’s, *Counties’ Role in Health Care Delivery and Financing* 3, 5-15 (July 2007),  
 23 archived at <https://perma.cc/Z6SX5JD5>; Eileen Salinsky, Nat’l Health Policy Forum, *Governmental Public*  
 24 *Health: An Overview of State and Local Public Health Agencies* 9-10 (Aug. 18, 2010), archived at  
 25 <https://perma.cc/E48M-ADZH>.

26 <sup>6</sup> “Because those without insurance generally lack access to preventative care, they do not receive treatment  
 27 for conditions—like hypertension and diabetes—that can be successfully and affordably treated if diagnosed  
 28 early on. When sickness finally drives the uninsured to seek care, once treatable conditions have escalated  
 into grave health problems, requiring more costly and extensive intervention.” *NFIB*, 567 U.S. at 594  
 (internal citations omitted) (opinion of Ginsburg, J.); *see also* The Nat’l Academies’ Inst. of Med., *Care*  
*Without Coverage: Too Little, Too Late* (2002), archived at <https://perma.cc/T542-Q8YP>; Benjamin T. Squire  
 et al., *At-Risk Populations and the Critically Ill Rely Disproportionately on Ambulance Transport to*  
*Emergency Departments*, 56 *Annals Emergency Med.* 341, 346 (2010).

1 absence of capable, culturally competent care, our residents are more likely to develop chronic  
 2 diseases—the persistent, prevalent, but preventable conditions such as hypertension, diabetes, certain  
 3 heart diseases, and obesity, that are among the most common and costly of America’s health  
 4 problems, and that increase the risk of severe illness from COVID-19.<sup>7</sup> Without early behavioral  
 5 healthcare, mental health and substance use costs also swell, potentially forcing *amici* to divert finite  
 6 funds from other critical functions or to further tax the public.

7 By prohibiting discrimination in healthcare and enhancing access to care, the ACA allowed  
 8 many *amici* to deliver the ongoing primary and preventative healthcare services that produce better  
 9 health outcomes for our residents sooner, in more appropriate settings, and at lesser expense. With  
 10 the support of the ACA’s health insurance expansions and its array of patient-protective provisions,<sup>8</sup>  
 11 state and local governments have saved billions in reduced uncompensated care costs in the decade  
 12 since the ACA was enacted.<sup>9</sup>

13 The Final Rule threatens these gains. It is intended and expected to reduce individuals’  
 14 access to needed insurance benefits, promote refusals of needed services, authorize discriminatory  
 15 and substandard care, and, ultimately, disconnect entire communities from the primary and  
 16 preventative healthcare services that lead to better health outcomes at lesser expense. “It is  
 17 implausible that Congress meant the Act to operate in this manner.” *King v. Burwell*, 135 S. Ct.  
 18 2480, 2493 (2015).

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 23 <sup>7</sup> Ctrs. for Disease Control & Prevention, *Coronavirus Disease 2019: People Who Are at Higher Risk* (Apr. 15, 2020), archived at <https://perma.cc/UR8W-LNYU>.

24 <sup>8</sup> See, e.g., 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a) (preventing health insurance denials because of  
 25 people’s pre-existing conditions); 300gg, 300gg-4(b) (barring higher premium charges based on health  
 26 status); 300gg-11 (prohibiting lifetime or annual limits on the value of essential health benefits); 300gg-12  
 (banning rescission, a previously common practice where insurance companies rescinded coverage when the  
 insured suffered a catastrophic illness); 300gg-19 (guaranteeing beneficiaries the right to appeal adverse  
 coverage decisions); 18022(c) (imposing annual out-of-pocket maximums for covered benefits).

27 <sup>9</sup> See, e.g., Larisa Antonisse et al., Kaiser Family Found., *The Effects of Medicaid Expansion Under the ACA:  
 28 Updated Findings from a Literature Review* 8-11 (Mar. 28, 2018), archived at <https://perma.cc/GU93-U9DE>.

## II. Discrimination Against Our LGBTQ Residents Imperils Public Health and Welfare

Laws embodying a “commitment to eliminating discrimination . . . serve[] compelling state interests of the highest order.” *Roberts v. U.S. Jaycees*, 468 U.S. 609, 624 (1984).

Nondiscrimination laws like Section 1557, which embody this commitment, make it clear that everyone deserves equal treatment and safety in the delivery of their healthcare. Despite this commitment in the ACA, and despite the dispositive and recent command of the Supreme Court in *Bostock v. Clayton County Georgia*, 140 S. Ct. 1731 (2020), the Final Rule nevertheless enshrines exclusion into Section 1557’s facially neutral federal nondiscrimination provisions. The Final Rule *itself* stigmatizes and harms.

As the State of Washington details, the Final Rule also enables healthcare providers to reject, humiliate, demean, and discriminate against people in need of life-affirming and lifesaving healthcare. Such discrimination is already rampant: in a 2010 survey, 70 percent of transgender respondents and nearly 56 percent of lesbian, gay, or bisexual respondents reported “being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive.”<sup>10</sup> In a study of LGBTQ adults, “13% reported having objects thrown at them, 23% reported being threatened with violence, . . . almost half were targets of verbal abuse,” and “21% reported violence or a property crime.”<sup>11</sup>

The discrimination that the Final Rule enacts and invites harms health in ways that endure beyond a specific encounter or episode. The lasting negative effects of discrimination on health are well-researched, abundant, and severe: discrimination “has a significant negative effect on both mental and physical health, . . . produces significantly heightened stress responses, and is related to

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<sup>10</sup> Lambda Legal, *When Health Care Isn’t Caring: Lambda Legal’s Survey of Discrimination Against LGBT People and People with HIV* (2010), archived at <https://perma.cc/UF9F-444M>.

<sup>11</sup> Valarie K. Blake, *Remedying Stigma-Driven Health Disparities in Sexual Minorities*, 17 *Housing J. Health L. & Pol’y* 181, 201-02 (2017), archived at <https://perma.cc/Q3Q4-J554> (citing Gregory M. Herek, *Confronting Sexual Stigma and Prejudice: Theory and Practice*, 63 *J. Soc. Issues* 905, 908-09 (2007)).

1 participation in unhealthy and nonparticipation in healthy behaviors.”<sup>12</sup> Discrimination is linked by  
 2 substantial evidence to a range of negative mental health outcomes, including depression,  
 3 psychological distress, anxiety, and diminished well-being.<sup>13</sup> Physically, discrimination causes  
 4 “exaggerated cardiovascular responses to stress,” as exhibited by changes in blood pressure and  
 5 cortisol levels and other negative physical effects, all of which “may erode an individual’s protective  
 6 resources and increase vulnerability to physical illness” and “lead to wear and tear on the body.”<sup>14</sup> It  
 7 thus increases the risk of certain diseases, such as depression, obesity, schizophrenia, heart disease,  
 8 metabolic syndrome, rheumatoid arthritis, fibromyalgia, and allergic conditions.<sup>15</sup> Discrimination  
 9 also “leave[s] individuals with less energy or resources for making healthy behavior choices,” which  
 10 leads to “health behaviors that have clear links to disease outcomes,” as well as “nonparticipation in  
 11 behaviors that promote good health,” such as seeking preventative healthcare.<sup>16</sup> Indeed, people who  
 12 experience frequent discrimination are three to nine times less likely to seek healthcare.<sup>17</sup> When  
 13 patients who face or fear facing discrimination from their healthcare providers do seek medical care,  
 14 the care they receive is less effective. The patients are less likely to disclose important clinical  
 15 information,<sup>18</sup> less likely to comply with their providers’ recommendations, and more likely to report

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 19 <sup>12</sup> Elizabeth A. Pascoe & Laura Smart Richman, *Perceived Discrimination and Health: A Meta-Analytic Review*, 135 *Psych. Bull.* 513, 513 (2009).

20 <sup>13</sup> *Id.* (citing Yin Paradies, *A Systematic Review of Empirical Research on Self-reported Racism and Health*,  
 21 35 *Int’l J. Epidemiology* 888–901 (2006); David R. Williams et al., *Racial/Ethnic Discrimination and Health: Findings From Community Studies*, 93 *Am. J. Pub. Health* 200–08 (2003)).

22 <sup>14</sup>*Id.* at 513-14.

23 <sup>15</sup> *Id.* at 544.

24 <sup>16</sup> Elizabeth A. Pascoe & Laura Smart Richman, *Perceived Discrimination and Health: A Meta-Analytic Review*, 135 *Psych. Bull.* 513, 514 (2009) (describing how discrimination leads individuals to make decisions that lead to health negatives outcomes, such as smoking, alcohol and substance abuse, and unprotected sex, and to avoid protective behaviors, such as cancer screenings and diabetes self-management).

25 <sup>17</sup> Sarah Wamala et al., *Perceived Discrimination, Socioeconomic Disadvantage and Refraining from Seeking Medical Treatment in Sweden*, 61 *J. Epidemiology Community Health* 409, 409 (2006), archived at <https://perma.cc/9R2P-VPK6>.

26 <sup>18</sup> Valarie K. Blake, *Remedying Stigma-Driven Health Disparities in Sexual Minorities*, 17 *Housing J. Health L. & Pol’y* 181, 211 (2017).

1 receiving poor quality care.<sup>19</sup> Concealing one’s LGBTQ status from a healthcare provider, in  
 2 particular, is associated with worse mental health outcomes, greater risk of cancer, greater risk of  
 3 infectious disease, and more rapid HIV symptoms.<sup>20</sup> HHS itself is well aware of the harms of  
 4 discrimination, including against LGBTQ people in particular, and recognizes discrimination as a  
 5 key component of individual and public health.<sup>21</sup>

6 The harms from discrimination ripple out into our communities as a whole. When our  
 7 LGBTQ community members are subjected to discrimination, the welfare of their children is also  
 8 jeopardized, including the welfare of the foster and adopted children whom same-sex couples so  
 9 often rear and raise.<sup>22</sup> Discrimination against a parent or caregiver is associated with poor health  
 10 outcomes for children, including potentially lasting physical, mental, socioemotional, and  
 11 developmental harms.<sup>23</sup> The cascading costs of discrimination are especially expensive for local  
 12 governments, which bear primary responsibility for managing public safety-net benefits, economic  
 13 supports, child welfare systems, and emergency and transitional housing.

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 16 <sup>19</sup> Maureen R. Benjamins & Steven Whitman, *Relationships Between Discrimination in Health Care and*  
 17 *Health Care Outcomes Among Four Race/Ethnic Groups*, 37 J. Behav. Med. 403 (2014).

18 <sup>20</sup> Valarie K. Blake, *Remediating Stigma-Driven Health Disparities in Sexual Minorities*, 17 Housing J. Health  
 19 L. & Pol’y 181, 211 (2017) (citing Larissa A. McGarrity & David M. Huebner, *Is Being Out About Sexual*  
 20 *Orientation Uniformly Healthy?: The Moderating Role of Socioeconomic Status in a Prospective Study of*  
 21 *Gay and Bisexual Men*, 47 Annals Behav. Med. 28, 28–29 (2014)).

22 <sup>21</sup> Office of Disease Prevention and Health Promotion, *Discrimination*, Healthy People 2020, archived at  
 23 <https://perma.cc/C3GG-3VKD> (HHS decade-long Healthy People 2020 public health campaign); see also  
 24 Office of Disease Prevention and Health Promotion, *Access to Health Services*, Healthy People 2020,  
 25 archived at <https://perma.cc/8HB4-WLZV>.

26 <sup>22</sup> Williams Institute, UCLA Sch. of Law, *How Many Same-Sex Couples in the US Are Raising Children?*  
 27 (2018), archived at <https://perma.cc/56AA-HJJJ> (finding “[s]ame-sex couples with children were far more  
 28 likely than male/female couples with children to have an adopted child (21.4% versus 3.0%) and/or a foster  
 child (2.9% versus 0.4%)”); Williams Institute, UCLA Sch. of Law, *Research Report on LGB-Parent*  
*Families* (2014), archived at <https://perma.cc/S3QP-UVHG> (“Same-sex couples are approximately 4.5 times  
 more likely than different-sex couples to be rearing adopted children.”).

<sup>23</sup> Eileen Condon et al., *Associations Between Maternal Experiences of Discrimination and Biomarkers of*  
*Toxic Stress in School-Aged Children*, 23 Maternal & Child Health J. 1147-51 (2019); see also Nia J. Heard-  
 Garris et al., *Transmitting Trauma: A Systematic Review of Vicarious Racism and Child Health*, 199 Soc.  
 Science & Med. 230-40 (2018), archived at <https://perma.cc/WVJ5-Z7EW> (longitudinal meta-analysis  
 finding vicarious discrimination against caregivers associated with physical, mental, socioemotional, and  
 developmental harms for children).

1 Many *amici* invest heavily to help counteract the weight of healthcare discrimination against  
2 their LGBTQ residents. The City of Chicago funds community-based organizations that specialize  
3 in providing care for LGBTQ residents who face discrimination from multiple intersectional  
4 characteristics, and it hires its own City staff solely to provide LGBTQ-specific resources. Howard  
5 County invests in outreach, community engagement work, and complaint investigations to serve its  
6 LGBTQ residents. The City of Oakland contracts for safe spaces for its LGBTQ children and youth  
7 based on its real-world recognition of the harms from rejection and discrimination to children and  
8 the need for care linkages and referrals to welcoming and supportive providers. The County of Los  
9 Angeles conducts provider education on how to competently care for transgender and gender  
10 nonconforming patients and also runs an LGBTQ committee for each of its medical centers. These  
11 policies make a palpable difference: LGBTQ patients consistently report that accessing care at the  
12 County's medical centers has changed their lives. The City of West Hollywood launched an HIV  
13 Zero Initiative to reduce the spread of, and harms from, HIV/AIDS, targeting its LGBTQ community  
14 because nearly all new HIV infections in the City are among gay and bisexual men.

15 Even in jurisdictions with deep commitments to inclusivity, discrimination against LGBTQ  
16 people in healthcare is pervasive. The County of Santa Clara, for example, has long been a leader in  
17 supporting LGBTQ rights—becoming the first county in the nation to establish an office dedicated  
18 to serving the LGBTQ community and, later, the first health system in its region to open a clinic  
19 specializing in healthcare for transgender, non-binary, and gender diverse people. The County's  
20 Office of LGBTQ Affairs has delivered trainings on how to provide LGBTQ-competent care to  
21 thousands of healthcare providers and champions LGBTQ community engagement work to build  
22 trust in County services. San José, the largest city in the County, earns a 100% score on the Human  
23 Rights Campaign's municipal equality index.<sup>24</sup> Yet nondiscrimination in healthcare in the County  
24 remains a major need and focus. The County regularly receives complaints about providers who  
25 deliberately call patients by the wrong names and the wrong pronouns, ask unnecessary questions

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27 <sup>24</sup> Human Rights Campaign, *San José, California 2019 Municipal Equality Index Scorecard*, archived at  
28 <https://perma.cc/4PL6-L2EQ>.

1 about patients’ genitals, house people in residential treatment settings in ways that threaten their  
 2 safety, and block access to gender-affirming care. The County’s Gender Health Center was never  
 3 meant to be the primary point of service for thousands of LGBTQ residents, yet all too often it must  
 4 serve as just that due to discrimination elsewhere. Until recently, many primary care providers in the  
 5 County who serve high numbers of LGBTQ patients did not know that they had LGBTQ patients, let  
 6 alone that they were failing them and failing to offer critical medications and screenings to prevent  
 7 costly lifelong conditions such as HIV/AIDS.

### 8 **III. The Final Rule Undermines the Trust Necessary for Healthy Communities**

9 The primary and preventative healthcare transformation that the ACA enabled depends on  
 10 trust—the trust that it takes to seek care, early and proactively; the trust that it takes to undergo  
 11 intimate examination and treatment; and the trust to listen and comply with a doctor’s orders.  
 12 Discrimination in healthcare shatters that trust. So much more must be done before even our most  
 13 inclusive health systems offer truly welcoming supportive care that earns the trust of all our patients.  
 14 The Final Rule eliminates even the hope that nondiscriminatory care is a shared goal. It directly  
 15 harms our residents, communities, and local governments and frays the fragile trust that *amici* invest  
 16 so much to create. These harms are all the more urgent and irreparable in the midst of a pandemic in  
 17 which our collective health so clearly depends on that of our neighbors.

18 Contrary to all of the foregoing, Defendants say the Final Rule will have “minimal” practical  
 19 effect because Defendants already made much of the 2016 Rule ineffective by failing to appeal  
 20 orders partially enjoining and then vacating it,<sup>25</sup> and because some states, localities, and covered  
 21 entities may protect patients anyway.<sup>26</sup> If the effect of the 2020 Rule were indeed minimal,

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 24 <sup>25</sup> The same court that declared the entire 900-page omnibus ACA unconstitutional and invalid because of a  
 25 single sentence also partially enjoined and vacated the 2016 Rule. *See Texas v. United States*, 340 F. Supp.  
 26 3d 579 (N.D. Tex. 2018), *affirmed in part, reversed in part*, 945 F.3d 355, *cert granted*, Nos. 19-1019 & 19-  
 27 840 (U.S. 2020); *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 696 (N.D. Tex. 2016) (partially  
 28 enjoining the 2016 Rule); *Franciscan All., Inc. v. Azar*, 414 F. Supp. 3d 928, 947 (N.D. Tex. 2019) (partially  
 vacating the 2016 Rule). Defendants’ unreviewable decision not to appeal that court’s vacatur of the 2016  
 Rule cannot now insulate Defendants’ rule change from judicial review.

<sup>26</sup> 85 Fed. Reg. at 37,225.

1 Defendants’ symbolic effort to make LGBTQ people “unequal to everyone else” would be all the  
2 more concerning. *See Romer v. Evans*, 517 U.S. 620, 635 (1996). Instead, however, the 2020 Rule  
3 creates and compounds harmful and costly health disparities, even in jurisdictions like the State of  
4 Washington that are committed to pluralism and respect for everyone.

5 **CONCLUSION**

6 *Amici* urge the Court to preliminarily enjoin the Final Rule.

8 Dated: August 7, 2020

Respectfully submitted,  
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**CERTIFICATE OF SERVICE**

I hereby certify that on August 7, 2020, the foregoing document was filed with the Clerk of the Court, using the CM/ECF system, causing it to be served on all counsel who have entered an appearance. I further certify that on August 7, 2020, service of the foregoing document will be accomplished via electronic mail to William.Lane2@usdoj.gov and via FedEx Overnight Delivery to the following:

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Dated: August 7, 2020

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